

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

15868

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|---|--|--|--|--|--|--|--|
| FILED MAY 14 1953 BIRTH NO. _____ | | REG. DIST. NO. 318 | | PRIMARY REG. DIST. NO. 1003 | | Registrar's No. 4294 | |
| 1. PLACE OF DEATH a. COUNTY _____ b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Saint Louis c. LENGTH OF STAY (In this place) 25 das d. FULL NAME OF HOSPITAL OR INSTITUTION Deaconess Hospital | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY _____ c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Saint Louis 2149 d. STREET ADDRESS (If rural, give location) 19 5347 Neosho | | | |
| 3. NAME OF DECEASED (Type or Print) a. (First) Joseph b. (Middle) A c. (Last) Kern | | | | 4. DATE OF DEATH (Month) (Day) (Year) 1 25 1953 | | | |
| 5. SEX M | | 6. COLOR OR RACE W | | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married | | 8. DATE OF BIRTH 10-18-1869 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Paymaster | | 10b. KIND OF BUSINESS OR INDUSTRY Bell Telephone Co | | 11. BIRTHPLACE (City and State or Foreign Country) St Louis, Missouri | | 12. CITIZEN OF WHAT COUNTRY? yes | |
| 13a. FATHER'S NAME Frederick Kern | | | | 13b. MOTHER'S MAIDEN NAME Mary Dauemheim | | 14. NAME OF HUSBAND OR WIFE Mathilde Kern 5347 Neosho | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO none | | 16. SOCIAL SECURITY NO. 491-16-8850 | | 17. INFORMANT'S SIGNATURE OR NAME ADDRESS Mathilde Kern 5347 Neosho, St. Louis, Mo | | | |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death. | | | | MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pyelonephritis (Chronic) ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Prostatic Hypertrophy DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. | | | |
| 19a. DATE OF OPERATION | | | | 19b. MAJOR FINDINGS OF OPERATION | | | |
| 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 21a. ACCIDENT SUICIDE HOMICIDE (Specify) | | 21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) | | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) | | 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? 610X | | | |
| 22. I hereby certify that I attended the deceased from Jan 2, 1952, to April 25, 1953, that I last saw the deceased alive on April 25, 1953, and that death occurred at 2 A. M., from the causes and on the date stated above. | | | | | | | |
| 23a. SIGNATURE (Degree or title) H. E. Jones, M.D. | | | | 23b. ADDRESS 110 South Central Ave | | 23c. DATE SIGNED April 25, 1953 | |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) | | 24b. DATE | | 24c. NAME OF CEMETERY OR CREMATORY | | 24d. LOCATION (City, town, or county) (State) | |
| Removal | | April 27, 1953 | | Valhalla Cemetery | | St Louis Co. Mo. | |
| DATE REC'D BY LOCAL REG. APR 27 1953 | | REGISTRAR'S SIGNATURE J. Carl Smith M.D. | | 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS C. HOFFMEISTER COLONIAL MORTUARY 6161 Chippewa St. Louis, Mo | | | |

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

Dr W E Jones

110 So Central

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed

Harry J. Lakey

Licensed Embalmer No. *2679*

P. O. Address *2814 S. Broadway*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.